

# **SUFFOLK COUNTY DEPARTMENT OF LABOR – *LIVING WAGE* UNIT**

## **APPLICATION FOR HARDSHIP ASSISTANCE** **UNDER THE *LIVING WAGE* LAW**

Living Wage Law, Suffolk County Code, Chapter 347 (2001)

**TO BE COMPLETED BY COVERED EMPLOYER AND FORWARDED TO MANAGING AGENCY**

CONTRACT AGENCY \_\_\_\_\_ REPRESENTATIVE \_\_\_\_\_

ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

\_\_\_\_\_

### **TOTAL ANNUAL BUDGET CALCULATION:**

ACTUAL PRE-*LIVING WAGE* \_\_\_\_\_

ESTIMATED POST-*LIVING WAGE* \_\_\_\_\_

ANNUAL BUDGET INCREASE \_\_\_\_\_

PERCENTAGE INCREASE OF TOTAL ANNUAL BUDGET \_\_\_\_\_

NUMBER OF EMPLOYEES AFFECTED BY THE *LIVING WAGE* REGULATIONS \_\_\_\_\_

AGENCIES SUPPLYING FUNDING \_\_\_\_\_

AMOUNT(S) \_\_\_\_\_

**ADDITIONAL COUNTY FUNDS REQUESTED:** \_\_\_\_\_

RATIONALE FOR APPLICATION for additional, hardship assistance from the County of Suffolk. Please include specific examples of jobs that will be lost, programs that will be cancelled and other consequences if further funding is not secured. Attach additional sheets as necessary:

I/we hereby declare under penalty of perjury under the Laws of the State of New York that the undersigned is/are authorized to provide this certification, and that all accompanying attestations are true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name & Title

\_\_\_\_\_  
County Vendor # (if known)

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Federal Employer ID#